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Obstacles to “race equality” in the English National Health Service: Insights from the healthcare commissioning arena

Sarah Salway^{a,*}, Ghazala Mir^b, Daniel Turner^c, George T.H. Ellison^e, Lynne Carter^d, Kate Gerrish^f^a School of Health and Related Research, University of Sheffield, UK^b Leeds Institute of Health Sciences, University of Leeds, UK^c Quirkos, UK^d NHS Yorkshire and Humber Commissioning Support, UK^e Centre for Anthropological Research, University of Johannesburg, South Africa^f School of Nursing and Midwifery, University of Sheffield, UK

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ABSTRACT

Inequitable healthcare access, experiences and outcomes across ethnic groups are of concern across many countries. Progress on this agenda appears limited in England given the apparently strong legal and policy framework. This disjuncture raises questions about how central government policy is translated into local services. Healthcare commissioning organisations are a potentially powerful influence on services, but have rarely been examined from an equity perspective. We undertook a mixed method exploration of English Primary Care Trust (PCT) commissioning in 2010–12, to identify barriers and enablers to commissioning that addresses ethnic healthcare inequities, employing:- in-depth interviews with 19 national Key Informants; documentation of 10 good practice examples; detailed case studies of three PCTs (70+ interviews; extensive observational work and documentary analysis); three national stakeholder workshops. We found limited and patchy attention to ethnic diversity and inequity within English healthcare commissioning. Marginalization of this agenda, along with ambivalence, a lack of clarity and limited confidence, perpetuated a reinforcing inter-play between individual managers, their organisational setting and the wider policy context. Despite the apparent contrary indications, ethnic equity was a peripheral concern within national healthcare policy; poorly aligned with other more dominant agendas. Locally, consideration of ethnicity was often treated as a matter of legal compliance rather than integral to understanding and meeting healthcare needs. Many managers and teams did not consider tackling ethnic healthcare inequities to be part-and-parcel of their job, lacked confidence and skills to do so, and questioned the legitimacy of such work. Our findings indicate the need to enhance the skills, confidence and competence of individual managers and commissioning teams and to improve organizational structures and processes that support attention to ethnic inequity. Greater political will and clearer national direction is also required to produce the system change needed to embed action on ethnic inequity within healthcare commissioning.

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1. Background

The importance of understanding and tackling healthcare inequities between ethnic groups, a significant factor in poor health outcomes, is increasingly recognised globally. However, the UK is

perhaps notable for its extensive legal and policy attention to this agenda, stemming from the 1965 White Paper *Immigration from the Commonwealth* which included explicit mention of migrant health. Since then, a steady stream of activity has aimed to enhance equity (often termed ‘equality’ in Britain) for patients regardless of ethnic background within the National Health Service (NHS), including: policy directives (e.g. the NHS Ethnic Health Unit, 1996); dedicated teams and senior posts (e.g. Ethnic Health Advisor, 1989; National Lead for Equality, 2013); and special initiatives (e.g. *Race for Health, 2006, Personal, Fair and Diverse*, 2010 and the *Equality Delivery*

* Corresponding author. School of Health & Related Research, University of Sheffield, Regent Court, 30 Regent Street, Sheffield, S1 4DA, UK.

E-mail address: s.salway@sheffield.ac.uk (S. Salway).

System (EDS) 2011, 2013) (Randhawa, 2007; NHS England, 2013). Policy activity has been supported by a strong legal framework, from the 1965 Race Relations Act to the Equalities Act of 2010; the latter placing significant duties upon the NHS to protect individuals from unfair treatment (Great Britain. Parliament, 2010).

However, despite this apparent commitment to equal services for equal need, inequitable access, experiences, and outcomes continue to be documented for minority ethnic groups across a range of English NHS settings. Some contexts perform particularly badly, notably mental health (NIMHE, 2003) and maternity care (Sivagnanam, 2004) but evidence of ethnic healthcare inequity is widespread (Lakhani, 2008; Bhopal, 2008). And, while it is important not to overlook pockets of good practice and innovation (see for example Latif, 2010) these examples illustrate that much ethnic healthcare disadvantage in the NHS is avoidable.

The apparent disconnect between national commitments and local provision of health services to multi-ethnic patient populations raises questions about how central government policy becomes translated into service design and delivery on the ground. In the current English context, the role of healthcare commissioning organisations is particularly pertinent. The term 'commissioning' is peculiar to England, with 'strategic purchasing' or 'planning and funding' being used elsewhere. Woodin (Woodin, 2006) describes healthcare commissioning as 'the set of linked activities required to assess the healthcare needs of a population, specify the services required to meet those needs within a strategic framework, secure those services, monitor and evaluate the outcomes' (p203). In England, where there is significant centralised direction and performance management from the Department of Health, (Gridley et al., 2012) commissioning also involves the implementation of national policy within the context of local needs and resources. As such, commissioning might be expected to be central to policy endeavours to tackle ethnic (and other) healthcare inequity. To-date, there has been little exploration of English commissioning from an equity perspective, with most research into minority ethnic healthcare focusing on service settings and patient experiences.

From 2002 to 2011, 152 Primary Care Trusts (PCTs) commissioned most local health services in England, (Greaves et al., 2012) with some specialist services and programmes (e.g. genetics and cancer screening) being commissioned regionally or nationally. The present investigation addressed two broad questions in relation to these PCTs: (1) To what extent and in what ways is ethnic diversity and inequity considered within healthcare commissioning? (2) What factors influence this commissioning practice?

2. Methods

A large multidisciplinary study was undertaken in 2010–13. University researchers and PCT managers worked closely to develop and deliver the project. Despite the policy decision to disband PCTs and introduce new commissioning structures being announced shortly after the project's inception, it was agreed by all stakeholders that the study would still generate valuable knowledge. We therefore proceeded with our focus on PCT commissioning, but data generation and analysis also included a speculative forward look to the General Practitioner (GP) – led, Clinical Commissioning Groups (CCGs) that would be formed in 2013.

Our conceptual framework recognised the terms 'race' and 'ethnicity' as complex, contested and closely related. Rather than subscribing to the notion that 'race' refers to biological features (such as skin colour) while 'ethnicity' refers to differences in cultural practices and beliefs, we concur with Gunaratnam's (Gunaratnam, 2003) assertion that 'race' has always been a far

broader concept than physical or genetic difference, also reflecting social and cultural distinctions. Likewise, though ethnicity tends to emphasise cultural and religious attributes, these characteristics are frequently (mis)represented as relatively fixed and inherent, being passed down from one generation to the next through endogamous marriage as well as via socialisation. As such, we recognised the diverse biosocial character of both these concepts. However, in keeping with common current UK practice, we opted to use 'ethnicity' and 'ethnic group' in our fieldwork and research outputs. That said, as already noted above, the terms 'race equality' and 'racism' are often used in UK policy documentation to refer to (action on) discrimination against groups defined by their ethnic identity, illustrating the interchangeability of these terms in the UK setting.

We conceptualised commissioning action as resulting from dynamic interactions between diverse actors who exercise individual agency but are constrained within organisational rules, structures and processes. These organisational characteristics are in turn situated within the wider healthcare policy context and broader socio-political setting. We were influenced by organizational studies that recognise the dynamic inter-play between micro-, meso- and macro-level factors, (Lam, 1997) and the complex and contested nature of healthcare policy-making (Blackman et al., 2006). We also drew on socio-cognitive perspectives that look beyond technical skills and resources to explore how values, worldviews and emotions can shape professional actions (Ringberg and Reihlen, 2008; Hunter, 2005; Gunaratnam and Lewis, 2001). We sought to expose the taken-for-granted 'ways of being and doing', viewing healthcare organisations as culturally embedded and politically contingent (Freedman, 2005). These perspectives link to work that highlights the historical influence of European and North American imperialism on current inequalities in power, wealth and cultural norms at local, national and international levels and on the production and use of knowledge (Connell, 2007). This conceptual framework meant that even where commissioning action appears unpredictable, we recognised the presence of 'deep structures' that constrain processes in comprehensible ways.

Empirical work involved three complementary phases combining depth and breadth of investigation. First, in-depth interviews with 19 national Key Informants (KIs; self-reported ethnicity White British (9) and non-White ethnic categories (10)) generated a range of insights on the PCT commissioning context, wider policy and potential future progress on inequalities. Participants were initially identified by networks of association followed by snowball sampling. Respondents had broad experience within healthcare policy making, most having held a variety of senior roles within central or regional government, the NHS or the third sector, and most having an interest in: equity and diversity; commissioning; and/or health disparities. Respondents were emailed or telephoned to provide study information and invite participation; three people declined to participate. We followed Hunter's (2005) suggested narrative interview style, employing a loose guide and emphasising dialogue to access implicit understandings and encourage discussion. Interviews were audio recorded with consent and transcribed verbatim. A theory-informed coding scheme (120 codes within 10 broader themes) was developed, piloted and iteratively refined by all research team members. Coding of transcripts was undertaken by each interviewer, with around 20% checked by a second researcher. Following coding, a series of team analysis workshops developed and refined interpretations. This phase also involved documentation of 10 'good practice' examples identified by KIs or via the minority-ethnic-health jiscmail network.

Next, we undertook case studies in three PCTs in the north of England (serving local populations comprising between 18.9% and

36.1% non-White minority ethnicity). Case study methodology allowed integration of data on a number of levels alongside contextual analysis of events and relationships to provide understanding of complex situations (Keen, 2006). The case studies explored both strategic-level commissioning work undertaken by senior groups within each PCT, and operational-level commissioning undertaken within specific work-streams (two each in two of the PCTs and a fifth in the final PCT; covering: maternity; emergency care; mental health; and cardiac care). After initial mapping of relevant people, structures and processes, data were generated through a range of methods employing loosely structured templates. A total of 75 individual interviews (respondent self-reported ethnicity White British (62) and non-White ethnic categories (13)) were completed. We undertook reviews of 190 documents and 166 h of formal observation (across 20 different organisational spaces, five of which involved several actors of both White and non-White visible ethnic identity). Numerous informal observations and interactions (recorded in field notes) within each PCT over a nine month fieldwork period complemented these methods. Data from the interviews, documentary analyses and observational work were systematically organised and indexed against the previously developed coding framework. Analysis sessions involved all team members in the inductive and interpretive identification, and subsequent testing, of emerging themes. Narrative summaries were first prepared for each strategic- and operational-level case study. Structured thematic templates were then completed for each case study, integrating data to confirm factors shaping commissioning practice. Cross-case comparative analysis then identified relational and substantive patterns. Face-to-face team workshops and iterative production of analytical memos were used to agree integrated findings.

Finally, we held three national-level workshops with a total of 38 people from a wide range of commissioning roles and organisations, and with diverse self-reported ethnicities, including: PCTs; NHS provider organisations; Clinical Commissioning Groups; the Department of Health; Local Government; research organisations; third sector provider and policy organisations. Workshops shared study findings and invited participant reflections in order to further refine and test the transferability of the claims and to consider their likely relevance to newly emerging CCGs. Ethical approval was obtained from the National Research Ethics Service (Nottingham Committee 2, reference 10/H0408/103), and governance approval was gained from participating PCTs.

3. Findings

Our data allowed us to describe whether, and how, attention to ethnic diversity and inequity was manifest by: the wider macro-level policy context; commissioning organisations' meso-level cultures and structures; and individual managers' and teams' micro-level actions; as well as the interplay of structures, processes and procedures across these levels. The overall picture was of very limited and patchy attention. Three inter-related themes offer both reasons and mechanisms relating to this state of affairs: marginalisation; ambivalence; and a lack of clarity and confidence. These themes were resonant across the three case study sites and the national data. Further, as discussed more elsewhere and below, (Turner et al., 2013) our data suggested that these core obstacles were likely to persist in the new commissioning structures.

3.1. Marginalisation

All national KIs felt that attention to ethnic diversity and inequity was a marginal concern within English national healthcare

policy, an assessment reiterated by respondents in all case studies and all three national workshops.

National KI: SHA Senior Manager: *"It's the area itself that gets the discrimination, that gets less resource, that gets the less importance. Which of [the] agendas do you think is going to be keeping people awake at night time? It will not be the inclusion agenda. There is a hierarchy in the importance of areas within the NHS."*

While some respondents felt there had been some progress under the 1997–2000 Labour government, all agreed that other priorities took precedence with little improvement over several decades. Respondents recognised potential synergies between action on ethnic healthcare inequity and other prominent drivers – particularly quality, efficiency and the broader health inequalities agenda – but they identified little alignment at macro-level in practice.

National KI: 3rd Sector Senior Manager: *"One of the things I'm struck by, is over the last ten years, it's always been one or two proactive [places] like that, and there's all these others where there is less happening. Why has that whole curve not shifted over time?"*

National KI: 3rd Sector Manager & Analyst: *"I said repeatedly that it was completely unhelpful that the previous policy agenda had health inequalities here and the equality agenda here."* [*indicates with arms outstretched]

Macro-level marginalisation was confirmed by our review of the national commissioning support infrastructure. Government aspiration for commissioning organisations to drive up service quality and efficiency was reflected in the range of resources available, including: comparative expenditure data; benchmarking of quality indicators; and a growing number of detailed disease-focused commissioning tool-kits. Few of these national resources included any consideration of ethnic diversity and inequity. Further, the materials developed nationally in support of ethnic (and other) equalities work were noticeably less extensive and sophisticated. Respondents also highlighted the inadequacy of national resources which convey the impression that the agenda is of low importance. A particular concern was the lack of performance management.

National KI: 3rd Sector Senior Manager: *"We measure everything else within the NHS. We've got targets; over the top most of the time. But around this agenda, we've never really had measurement."*

The only exception to marginalisation was in relation to mental health, within which several KIs noted significant nationally-driven activity aimed at improving understanding of, and action on, ethnic inequities. However, even here respondents highlighted the lack of embedded and sustained progress on the ground that had resulted.

Our case studies, national KI testimony and workshops all suggested that marginalisation within macro-level national policy was mirrored within meso-level PCT organisational cultures and structures. Across the three case studies we found no sign that attention to ethnic diversity and inequity was embedded within commissioning processes. It was not seen as 'core' or (as one commissioner put it: *"not mission critical"*) to commissioning. Rather than being embedded within processes of understanding and responding to the healthcare needs of the local population, ethnic (and other) equalities work was generally constructed as a matter of legal compliance or, as one respondent explained, *"a nicety, not a necessity"*.

National KI: SHA Senior Manager: *“How are the priorities, as set out in the Single Equality Scheme, linked back to the strategic plans of that organisation [PCT]? Most of the time those priorities don’t feature anywhere near any of the strategic business plans at all.”*

Marginalisation at meso-level was reflected in the taken-for-granted structures and processes of commissioning work. The small (and dwindling) number of staff employed with an equality and diversity (E&D) remit was noticeable, as well as in their low grade and their organisational positioning, usually distant from and with few links to the “engine room” of commissioning. The make-up of ‘task-and-finish’ teams and other functional groupings that we examined failed to include those with E&D expertise and there were no processes that drew attention to this omission. In keeping with the macro-level picture, agendas other than equity and diversity (particularly quality and efficiency) had much greater prominence within the PCTs as reflected in larger teams, coherent programmes of work and visible statements of affirmation by senior leaders.

There was no evidence of the quality and equity agendas being aligned, despite potential synergies. The quality assurance documents reviewed made no reference to equalities issues and quality indicators were not regularly broken down by ethnic group. Work related to the EDS was undertaken by E&D staff without reference to the quality agenda and with no involvement from quality teams. Importantly, even the health inequalities work (driven by public health teams in all case study sites) included variable attention to ethnicity, with socioeconomic and geographical inequalities being far more prominent.

At micro-level, marginalisation was reflected in the worldviews and behaviours of individual commissioners and commissioning teams. Most commissioners did not view identifying and tackling ethnic inequalities in healthcare access, experience or outcomes as part-and-parcel of their job. Commissioners exploring efficiency issues routinely overlooked the relevance of ethnic diversity and inequity or dismissed such attention as unnecessary detail, rather than something that might improve understanding and action.

Case Study: PCT Public Health Commissioning Manager
“There’s a mind-set that says if we do anything for BME [Black and Minority Ethnic] communities that’s on top of what we already do, rather than what we already do should incorporate the needs of BME communities.”

Moreover, where we did identify areas of good practice, and individuals who had instigated change, the work tended to be project-based and isolated. Meso-level cultures and structures failed to support the sharing of such micro-level learning, meaning no impact on ‘core’ commissioning work and continued marginalisation of the agenda.

3.2. Ambivalence

Some KIs suggested that marginalisation of the ethnic equity agenda at macro-policy level was explained in part by ambivalence among senior leaders. Respondents argued that some senior policy makers are unconvinced that important ethnic inequalities exist. Other respondents felt that the default position within DH and much of the NHS is simply to overlook ethnic inequity; to not recognise its importance.

National KI: SHA Senior Manager: *“Decision makers who feel that we already have a fair society, that we already have an equal*

world. So therefore all this inclusion and equality resources we’re putting in is political correctness gone mad.”

Some respondents identified more active forms of obstruction, linked to the protection of professional boundaries and vested interests, or to a world-view that fundamentally contests minority ethnic entitlement and representation. Notwithstanding variation in the perspectives felt to underpin senior ambivalence, a lack of leadership was commonly reported by KIs.

National KI: SHA Senior Manager: *“Very rarely do we get key players at a senior level pushing this agenda.”*

Ambivalence—at times manifested as active resistance—to the consideration of ethnic inequity within commissioning work was clearly reflected at meso-level in all three case study PCTs. While some high level strategic documents made general reference to the importance of meeting the needs of ethnically diverse local populations, these statements were rarely translated into concrete action plans or performance indicators. We found that culturally-embedded organisational processes filtered out, or watered down, attention to ethnic inequity. In one site mid-level managers had produced a detailed strategy document explicitly focused on the health and social care needs of local minority ethnic groups. Despite repeated attempts, and involvement of local stakeholders, they failed to gain endorsement from senior staff. The document remained in draft form, having no impact on commissioning practice. In another site, we observed that attention to ethnicity within a commissioning team was completely lost when there was a change in team leadership. Despite earlier consideration, the final service specification failed to include performance indicators related to ethnicity. Similarly, information on minority ethnic health needs, sourced for inclusion in a briefing pack for practitioners, was subsequently omitted from the final version. (In)attention to ethnic inequity was rarely penalised or rewarded within organisational processes and senior staff at times publicly queried the legitimacy of this agenda. In one forum, we observed commissioners questioning whether it was right (and ultimately deciding not) to challenge a large provider organisation on an issue directly related to gaining insight into minority ethnic needs. Across all three sites, Equality Impact Assessments (routine processes intended to ensure attention to equalities within work-streams) though considered useful in theory by many respondents, were generally conducted with little resource and acknowledged to be ‘tick-box’ exercises unconnected to action. National KIs confirmed pervasive ambivalence at PCT level by providing varied examples of inconsistent commitment and resistant attitudes towards the ethnic equity agenda.

Our observations of micro-level commissioning work further illustrated ambivalence regarding the legitimacy of this agenda. Across a wide range of commissioning areas respondents’ world-views sat uncomfortably with an explicit focus on meeting the needs of minority ethnic groups. Respondents talked about the need not to be seen to privilege particular groups and the importance of improvement work benefiting “the whole population”. Emotions were in evidence here, with commissioners expressing fear about the cost and complexity involved in addressing ethnic inequities.

Case Study: PCT Public Health Specialist *“So I always feel there’s this enormous tension between how do we do the best for the most, against balancing up how much do we then pull off to spend a proportionally more amount of money and time targeting a group which they might have greater needs.”*

Case Study: GP and CCG member. *"I think you've got to be very careful not to be seen to be offering anything preferential either. It's a bit of a minefield when it comes to setting up services for minority groups and how other groups react to that."*

Some case study respondents told us explicitly that the contested legitimacy of this agenda at organisational level undermined their individual commitment.

Case Study: Senior Commissioning Manager: *"We mention it once, maybe twice, and then we give up."*

Importantly, several respondents who self-identified as belonging to a minority ethnic group expressed ambivalence towards championing this agenda. Some were concerned that pushing the agenda could be construed as mixing personal and professional issues, and thereby undermine their own credibility. Others expressed exhaustion or frustration at having to persistently raise the issue without support from colleagues, a scenario often linked to organisational spaces being predominantly White.

Case Study: Senior Public Health Commissioning Manager *"I'm not saying it's the wrong thing to do to raise it. I'm saying it's personally a bit difficult when you're the only one raising it and you get the kind of vibe that you're the only one raising it as you're the only brown face in the room. And it shouldn't be that way."*

3.3. Lack of clarity and confidence

Both KI interviews and case study work revealed a lack of clarity at the macro policy level regarding how ethnic diversity and inequity should be understood and addressed within the health system. This appeared to both reflect and contribute to the marginalisation and ambivalence described above. Several national KIs identified a need for more clearly defined expectations around the role of commissioning in reducing ethnic healthcare inequities, as well as more open discussion of recurring complex issues. These included how commissioners should: conceptualise ethnicity and links to health; understand relationships between ethnic and socioeconomic disadvantage; determine reasonable service standards; work with providers to develop effective solutions; engage local communities; and identify and tackle discrimination. Our review of national-level policy documentation and guidance for commissioners – such as that relating to the EDS – highlighted vague statements and limited direction at both a conceptual and a practical level.

National KI: 3rd Sector Manager: *"All the things that come with low socioeconomic status are a factor in it. But there's various aspects to culture and language and other things entangled with this. You'll need to think about the two things at the same time, but conceptually it's quite tricky. I think this is a real problem. Unless that gets straightened out it is very difficult for people to know what they think they're doing, to understand 'What is this problem we're trying to solve here?'"*

At meso-level, the PCT organisational cultures and structures also reflected a lack of clarity and confidence in: absence of detail in strategic and operational documents; avoidance of certain areas of work perceived to be sensitive; use of external consultants because staff felt ill-equipped; expectations that BME staff would take responsibility for this agenda; and reliance on community organisations to represent minority ethnic needs. Our observations and KI

reports from elsewhere confirmed that understanding within commissioning organisations is often poor and that a lack of open debate – a reluctance to 'say certain things upfront and out loud' (National KI: Local Authority Consultant) – limited opportunities to clarify misconceptions, challenge prejudice or build confidence. Instead, organisational discourses tended to construct minority ethnic groups as 'hard-to-reach' (what one workshop participant translated as "easy-to-ignore") and meeting their needs as sensitive, costly and complex.

National KI: SHA Senior Manager: *"They [a PCT] had a race equality review but nobody would talk about race equality in the room. ... The local authority and the PCT are absolutely – it's the same in [name of place] – absolutely terrified that there'll be a backlash if they focus on BME communities."*

Limited confidence was also manifested at the micro level by commissioners contesting their responsibility to address ethnic inequity. In one case study, an established commissioning group acknowledged that their service user forum was heavily dominated by White British, middle-class people but regarded redressing this lack of representation as beyond their remit. It was common for commissioners to expect provider organisations to ensure services were accessible to all rather than specify the service characteristics needed to achieve equitable access. We found examples of commissioners deciding not to address low service uptake among minority ethnic groups because they perceived insufficient buy-in from provider organisations and felt ill-equipped to drive such improvement work. Some commissioners also appeared to shy away from performance monitoring against this agenda – particularly of large NHS providers – anticipating complexity and/or resistance by provider organisations.

While there were some exceptional individuals who sought to embed attention to this agenda within their work, the predominant picture was of commissioners who lacked the confidence and skills, and were at times fearful, to engage, perceiving this area of work to be complex and risky.

Case Study: PCT Public Health Senior Commissioning Manager: *"People's awareness of the issues is very variable. Some people struggle. People can be a bit sensitive about it. Am I writing it the right way? Am I using the right terminology?"*

Similarly, our KIs felt that many commissioners hold unsophisticated understandings around ethnicity and tend to stereotype and to blame minority ethnic people themselves for poor access or poor experiences, rather than considering the potential limitations of the services on offer. It was also noted that, where minority ethnic groups attracted significant commissioning attention, this was often prompted by concerns around a perceived inappropriate or excessive use of services rather than by identified unmet need.

Furthermore, those individuals who were more confident nevertheless reported poor support from policy and organisational levels to get to grips with challenging issues, such as the interplay between religious and ethnic identities and the role of socioeconomic disadvantage and racial discrimination in shaping health and healthcare among minority ethnic groups.

Case Study: PCT Public Health Senior Commissioning Manager: *"Yeah, so sometimes the inequalities faced by certain ethnic groups is more to do with poverty and lack of access to employment, compounded by discrimination and racism, and you know, sometimes we're not that good at, at sort of distinguishing that."*

In some cases, commissioners' lack of confidence to act was fuelled by limited data on patterns of ethnic healthcare inequities and a poor evidence base on effective interventional strategies. Indeed, some respondents at national and local level highlighted the failure to develop an adequate infra-structure to generate and mobilise evidence on ethnicity and health as a major obstacle to progress in this area. Some commissioners, having identified an area of ethnic inequity, then struggled to make progress on addressing it and this seemed to exacerbate the sense that 'nothing works'. However, we also found commissioners assuming a lack of data and evidence when in reality this was actually not the case, and investing little resource in seeking out relevant evidence.

3.4. Enabling factors

The fieldwork generated greater understanding and more illustrative examples of obstacles than of facilitators. Nevertheless, we did identify some areas of good practice and some common factors associated with commissioning work that paid explicit and thoughtful attention to ethnic diversity and inequity.

Importantly, however, we did not find evidence of systematic differences across the case study sites linked to organisational or wider contextual factors. Instead, the role of individual agency was striking. We found examples of individuals with strong commitment to the agenda producing innovative work despite, rather than because of, their wider organisational contexts. These individuals were often (though not always) PCT staff with a specific E&D remit. Observing the implementation of the EDS in two of the case study sites confirmed the central role of effective E&D staff in drawing in relevant evidence, ensuring in-depth assessments and effectively engaging local stakeholders. We found individuals working creatively to generate and use evidence of an inequity, for example by analysing service data to show underutilisation or poor patient experience in particular groups. Some E&D leads partnered with academics or public health data analysts to gather evidence demonstrating the need for improved services. Combining national and local data was used in some cases to identify likely areas of poor service uptake or under diagnosis of particular conditions in certain communities. For example, in one PCT national survey data on levels of coronary heart disease by ethnicity in conjunction with local population profiles and information about in-patient activity were used to identify potential ethnic inequalities in revascularisation and this led to a qualitative investigation of factors undermining healthcare access. Presenting and packaging evidence in the format valued by decision makers was important. For example, a summary matrix of key messages from community engagement work was better received by a PCT board than a longer account of respondents' experiences. We also found that progress was often associated with actors embedding attention to ethnic inequalities within other, core drivers. In a few cases, a national initiative had prompted such work, usefully alerting commissioners to the need to tackle inequities. In one good practice example, a local stroke awareness project had grown out of a national agenda and included tailoring of educational messages to minority ethnic communities. More commonly, however, commissioners eager to address ethnic inequalities had to identify creative ways of enhancing attention to this area. Appealing to the dominant focus on cost saving, some had made progress by developing business cases that demonstrated how meeting minority needs could mean greater efficiency. Others had sought to present equity issues as aspects of the quality agenda.

Respondents felt that having staff with an explicit E&D remit was beneficial and also stressed the importance of an ethnically diverse workforce to increase understanding of need. The role of

clear leadership was, however, also stressed by respondents, particularly in the context of ambiguous messages from central government. E&D staff at a senior grade and well-embedded within the core commissioning functions seemed to be important in enabling skills and commitment to develop across organisations.

National KI: 3rd Sector Senior Manager: *"It doesn't matter how brilliant, innovative, courageous, forward-looking operational folk are, they can only make a difference in a small corner of the world. If you've got good leadership then there's an opportunity for those innovative beings to flourish and for what they're doing to be extended into other areas of the organisation."*

Progress on ethnic inequity also seemed more common where commissioners effectively drew in varied stakeholders. The documented good practice examples all involved multi-professional teams. Commissioners relied heavily on other stakeholders in relation to understanding and addressing the health needs of their population. Commissioners struggle to bring about significant service redesign without the buy-in of provider organisations and particularly clinical colleagues. Further, there was often a large social distance between commissioners and minority ethnic service users and limited time available to develop detailed understanding of service realities. Providers, particularly frontline practitioners, had sometimes used their experience and insight to initiate and develop the improvement of a particular service. Engagement of wider stakeholders in the commissioning processes therefore appeared to increase the likelihood that commissioning intentions would reflect the needs of an ethnically diverse population and that such intentions would be translated into practice on the ground.

National KI: 3rd Sector Senior Manager: *"We arranged for about twelve, maybe fourteen, local community groups to host a meeting with four or five commissioners from elsewhere in the country. That, for the majority of commissioners who participated, was a life-changing event. Because for the first time they didn't feel they were going to meet with local communities to defend what they'd been doing. It was just an opportunity for them to listen and to hear. The impact of that was that when they got back to their local areas they set up similar ways of consulting with local communities."*

The importance of networks across organisations was also identified since these could provide support to those working on equity issues. In one case study site, a network of E&D leads had resulted in shared practice around equality monitoring and community outreach, as well as increased confidence and motivation. Other respondents also highlighted supportive regional networks.

Case study: PCT Senior commissioner: *"I think that's one of the things I've really found useful, and I don't think I've realized how much until we've not met for a while, because it's quite an isolating job being Head of Equality."*

4. Discussion

This study was motivated by the observation that progress towards equitable healthcare access, experiences and outcomes for minority ethnic people is limited in England given the apparently strong legal and policy framework. We sought to (i) describe the extent to which ethnic diversity and inequity is considered within healthcare commissioning and (ii) understand influencing factors.

Fieldwork was conducted at a time of NHS restructuring and this

context may have produced a more negative picture than a study conducted at a more stable time. It is also possible that selection of case study PCTs on the basis of 'good practice' might have generated greater insight into enabling factors. It is also important to acknowledge that provider organisations (NHS and non-NHS) importantly shape the design and delivery of services independently of commissioning action. Nevertheless, given the UK government's continued aspiration for local commissioning organizations – now re-structured in England into Clinical Commissioning Groups – to have a stronger role in shaping services, (NHS Commissioning Board, 2011) this focus was important and novel. Further, the combined depth and breadth in data generation gives confidence that our findings have wide and ongoing relevance across England (see below).

Our findings confirm and extend earlier work outside the commissioning arena on factors that undermine and support ethnic healthcare equity. Overall, we found very limited attention to ethnic inequity within English healthcare commissioning. Marginalization of this agenda, along with ambivalence and limited confidence, perpetuated a reinforcing inter-play between individual managers and teams, their organisational setting and the macro policy context.

Our findings indicate that, despite the apparent indications to the contrary, ethnic equity is a peripheral concern within national healthcare policy and is poorly aligned with other more dominant agendas, mirroring Connell's (Connell, 2007) description of the indifference or resistance of those in power to marginalized populations and supporting the claim that the multi-ethnic reality of English society is largely unacknowledged within many areas of policy (Anionwu and Atkin, 2001). Even the health inequalities agenda was found to be poorly specified with respect to ethnic inequity, a finding resonating with earlier work and distinguishing the English context from the US (Exworthy et al., 2006). There was evidence of significant ambivalence, and even active resistance, to promoting this agenda among senior managers, reflected in the limited resources allocated. In contrast to other areas, such as quality and efficiency, central policy-makers have failed to articulate clear, detailed commissioning expectations in relation to ethnic diversity and equity. We also found that ethnicity, inequity and racism remain uncomfortable topics within health-policy making circles, again supporting earlier claims (Bhui et al., 2012).

Potential synergies with other policy drivers – such as patient experience and quality – were generally not recognized and isolated instances of good practice did not lead to wider organizational improvements. Senior managers did not generally provide clear leadership. Rewards or sanctions for (in)action were not evident. There was heavy reliance on consultants and community-based organizations. Organizational cultures and structures provided little space for debate and discussion, with consequently few opportunities to clarify misconceptions, challenge preconceived ideas or build confidence. Locally, commissioning organizations approached ethnic equity (or "race equality") in line with a very narrow interpretation of legal compliance rather than as something integral to understanding and meeting the healthcare needs of their diverse populations; findings that are consistent with research in other policy arenas (Ahmed, 2007). Following the 1999 MacPherson Report, UK equalities legislation was developed to include the race equality duty which aimed to reduce institutional racism, defined as "the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin" (para 6.34) (The Stephen Lawrence Inquiry, 1999). Public Sector organisations, including the NHS, were now required to identify any inequalities linked to the ethnicity of their staff, job applicants, service users and potential service users and to take steps to reduce and eventually

remove those inequalities. MacPherson stated explicitly that institutional racism persists "because of the failure of the organisation openly and adequately to recognise and address its existence and causes by policy, example and leadership" (para 6.34). (The Stephen Lawrence Inquiry, 1999) Our findings illustrate how NHS commissioning organisations, even those which consider themselves to be compliant with equalities legislation, fail to provide this necessary policy, example or leadership.

Our exploration of micro-level healthcare commissioning work by individuals and teams showed that most did not consider understanding and tackling ethnic healthcare inequalities to be part-and-parcel of their job. The legitimacy of attending to minority ethnic needs was questioned, with staff expressing concerns about privileging particular groups and uncertainty regarding appropriate responses, findings that resonate with descriptions of dilemmas in social support provision (Atkin and Chattoo, 2007). Work in this area was commonly constructed as costly, complex and risky, with common fears about 'getting it wrong'; again, echoing the descriptions of 'fear' and 'professional uncertainty' documented among healthcare practitioners (Kai et al., 2007; Johnson, 2009). Limited confidence and commitment was reflected in commissioners contesting their responsibility to take action. Importantly, individuals with greater skill and commitment to ethnic equity (including some who self-identified as minority ethnic) often felt disempowered by inconsistent or resistant messages from managers and by unsupportive organisational contexts. This general lack of recognition was reinforced by the peripheral positioning of knowledge, experience and needs relating to people from minority ethnic backgrounds through their frequent exclusion from decision-making groups and commissioning processes and significant gaps in the evidence base. Where a more engaged relationship existed between commissioners and minority ethnic communities, mutual learning and a creative "politics of change" (Connell, 2007) (p222) could be stimulated, at times even connecting the concern to address ethnic inequalities with the dominant policy agenda.

4.1. A way forward?

Our findings support earlier conclusions regarding the need to enhance the skills, confidence and competence of individual managers and teams and to improve organizational systems and processes that support attention to ethnic diversity and inequity. We identified issues reported across other national contexts, including the need to: improve data collection and reporting by ethnicity (Thorlby et al., 2011); diversify the workforce (Dreachslin, 2007); address deficiencies in cultural competence (Came, 2014) and enhance meaningful engagement of minority communities (Cacari-Stone et al., 2014; Wilson, 2009).

Our findings also highlight the need for more fundamental action. Our evidence chimes with earlier work that has highlighted: poor understanding of the nature and causes of ethnic inequities in health and healthcare (Wilson, 2009); reluctance to engage with racism and exclusion (Bhui et al., 2012) and uncertainty regarding the entitlements of minority ethnic people (Atkin and Chattoo, 2007; Hepple, 1992), as well as historical influences on ethnic inequalities in power and the production of what counts as credible evidence (Connell, 2007). Further, given the top-down, performance-driven NHS culture, the absence of clear national direction is problematic. These are fundamental barriers to progress requiring an integrated response involving political leaders, commissioners, providers, patients, communities and researchers.

Ethnic (and other) equity must be given much greater visibility, legitimacy and resource at macro policy level. It must be aligned with core commissioning agendas, particularly quality, efficiency

and health inequalities, to ensure that resources directed to these priorities also work for, rather than against, action on ethnic inequalities. We must spell out more clearly: how and why ethnicity affects health and healthcare access; what standards of service provision are expected; and what commissioning responses are appropriate. Performance management and rewards for progress are needed. Further, recognising conceptual and operational complexity, mechanisms for sharing practice and enhancing dialogue are needed to improve clarity and confidence. Action to increase minority ethnic representation within the commissioning workforce and to empower communities and the third sector to challenge and support commissioners is also important for remodelling relations between marginalised and dominant actors and forms of knowledge (Connell, 2007). Thus, our findings highlight the continued need for more 'systems-based' approaches that recognise the institutionalised and structural nature of problem (The Stephen Lawrence Inquiry, 1999; Feagin and Bennefield, 2014).

The recent restructuring of English healthcare commissioning has brought actors into novel roles. Nevertheless, the recommendations identified here remain valid in the newly established system. While new structures and processes may be an opportunity for action on ethnic inequity, deeply embedded obstacles will likely persist unless this agenda becomes central to the ethos of 'health for all'. KIs in this study were largely pessimistic about future progress on ethnic equity as well as the wider health inequalities agenda (Turner et al., 2013). While they recognised that some GPs might bring in-depth understanding of the needs of their diverse patient populations, they felt that most were largely unaware of under-served groups. Respondents also highlighted the loss of expertise and relationships that accompanied restructuring which is likely to hamper progress. Nationally, whether the establishment of NHS England's Equalities and Health Inequalities team and Public Health England's Health Equity and Inclusion team can result in greater legitimacy, resource and direction and in turn more consistent, evidence-based commissioning to address ethnic healthcare inequity, remains to be seen.

We focused on the English commissioning arena, but our findings have wider relevance. The UK's strong legal framework and apparent policy commitment within the NHS belies a much more ambivalent and complex relationship to the notion of ethnic equity. Indeed, our findings reflect the wider lack of coherence in UK social policy and uncertainty regarding the form that multicultural Britain should take (Hepple, 1992). Those actors who seek to reduce ethnic healthcare inequities in other settings can usefully learn from the English experience.

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